

Area of study 2: Mental Health

Key knowledge:

This knowledge includes:

- concepts of normality and differentiation of mental health from mental illness
- systems of classification of mental conditions and disorders: underlying principles of classification; strengths and limitations of discrete categorical (DSM-IV and ICD-10) and dimensional (graded and transitional) approaches to classification of mental disorders
- use of a biopsychosocial framework (the interaction and integration of biological, psychological and social factors) as an approach to considering physical and mental health
- application of a biopsychosocial framework to understanding the relationship between stress and physical and mental wellbeing:
 - physiological and psychological characteristics of responses to stress including fight-flight response, eustress and distress; strengths and limitations of Selye's General Adaptation Syndrome
 - psychological determinants of the stress response; strengths and limitations of Richard Lazarus and Susan Folkman's Transactional Model of Stress and Coping
 - social, cultural and environmental factors that exacerbate and alleviate the stress response
 - allostasis (stability through change brought about by the brain's regulation of the body's response to stress) as a model that integrates biological, psychological and social factors that explain an individual's response to stress
 - strategies for coping with stress including biofeedback, meditation/relaxation, physical exercise, social support
- application of a biopsychosocial framework to understanding and managing simple phobia as an example of an anxiety disorder:
 - biological contributing factors: role of the stress response; role of the neurotransmitter gamma amino butyric acid (GABA) in the management of phobic anxiety
 - psychological contributing factors: psychodynamic, behavioural and cognitive models; the use of psychotherapies in treatment including cognitive behavioural therapy (CBT), systematic desensitisation and flooding
 - socio-cultural contributing factors: specific environmental triggers such as being bitten by a dog; parental modelling and transmission of threat information
 - the interaction between biological, psychological and socio-cultural factors which contribute to an understanding of the disorder and its management
- application of a biopsychosocial framework to understanding ONE of the following types of mental disorder and its management:

Mood disorder: major depression

 - biological contributing factors: role of genes in contributing to the risk of developing major depression; roles of the neurotransmitters serotonin and noradrenaline in major depression; the function of antidepressant medication in management
 - psychological contributing factors: learned helplessness; stress; the use of psychotherapies in management including cognitive behaviour therapy and psychodynamic psychotherapy
 - socio-cultural contributing factors: abuse, poverty, social isolation and social stressors as risk factors; support factors including family and social networks and recovery groups
 - the interaction between biological, psychological and socio-cultural factors which contribute to an understanding of the disorder and its management

OR

Addictive disorder: gambling

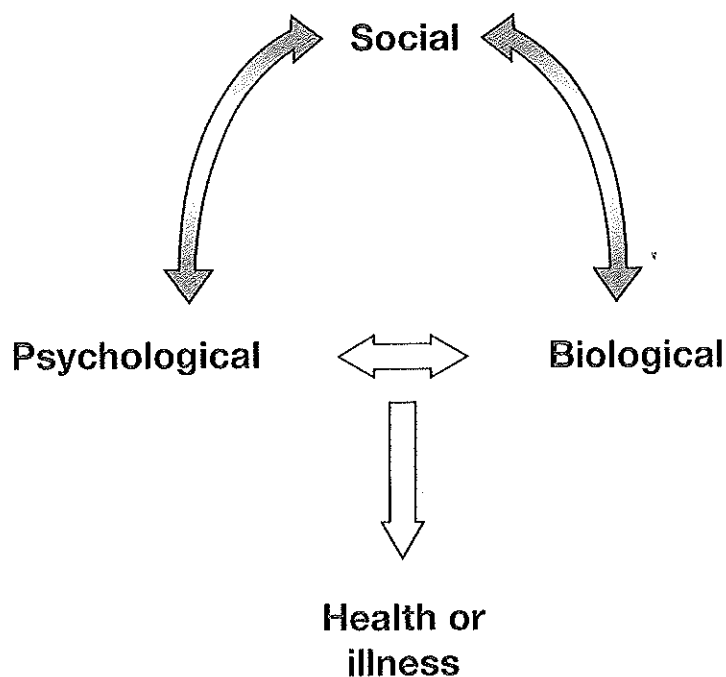
- biological contributing factors: role of the dopamine reward system and as a target for treatment
- psychological contributing factors: social learning theory and schedules of reinforcement; the use of psychotherapies in treatment including cognitive behavioural and psychodynamic therapies
- socio-cultural contributing factors: social permission of gambling opportunities; management including social network and recovery groups
- the interaction between biological, psychological and socio-cultural factors which contribute to an understanding of the disorder and its management

OR

Psychotic disorder: schizophrenia

- biological contributing factors: genetic predisposition; drug-induced onset; changes in brain activity; the use of medication that blocks dopamine to treat psychosis
- psychological contributing factors: impaired mechanisms for reasoning and memory; the use of psychotherapies in management including cognitive behavioural and remediation therapies, stress management
- socio-cultural contributing factors: social disadvantage, trauma and psycho-social stress as risk factors; psychoeducation, supportive social (including family) environments, removal of social stigma
- the interaction between biological, psychological and socio-cultural factors which contribute to an understanding of the disorder and its management

- research methods and ethical principles associated with the study of mental health, as outlined in the introduction to the unit.



- **concepts of normality and differentiation of mental health from mental illness**

There have been a number of different approaches to describing normality and abnormality with regard to mental processes and behaviour:

1. **Socio-cultural approach** – Behaviours that are considered appropriate or acceptable within a society are viewed as normal and those considered inappropriate or unacceptable are seen as abnormal.
2. **Functional approach**-Behaviour is considered normal if the person is able to live independently (i.e. function), but considered abnormal if they are unable to function in society.
3. **Historical approach**- Normal versus abnormal in a given society depends upon the era in which the judgement is made. Eg. Smacking a child.
4. **Situational approach**- Behaviour considered normal in one situation may be considered abnormal in another
5. **Medical approach**- Abnormal behaviours are seen to have an underlying biological cause and can usually be diagnosed and treated
6. **Statistical approach**- The majority of people, sometimes called the statistical average, behave in a certain way that is considered normal whereas behaviour displayed by a small minority, the statistical extremity is considered abnormal.

Differentiating mental health from mental illness

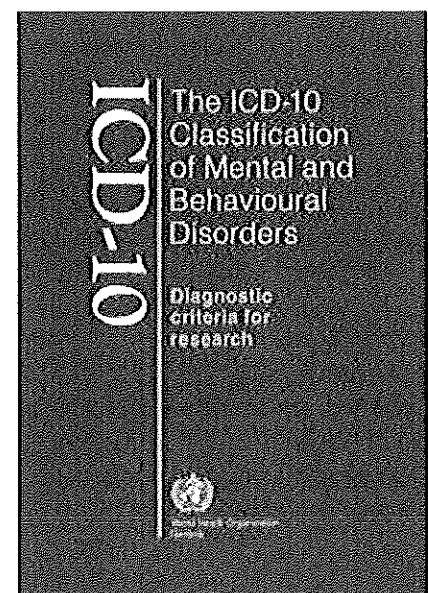
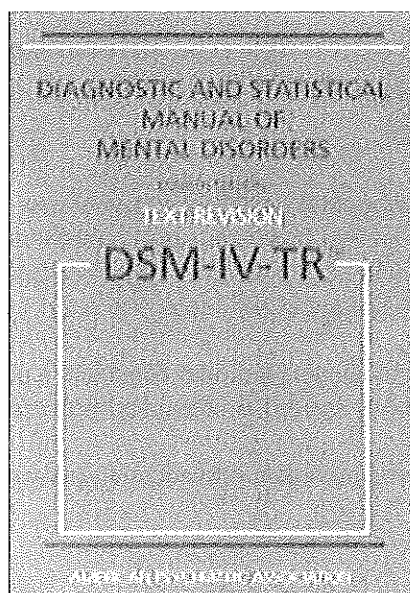
Mental health is the capacity to interact with others in ways that foster well being and optimise development throughout the lifespan. **Mental illness** refers to a psychological dysfunction that usually involves an inability to cope with everyday life and behaviours that are atypical within that culture.

- **systems of classification of mental conditions and disorders: underlying principles of classification; strengths and limitations of discrete categorical (DSM-IV and ICD-10) and dimensional (graded and transitional) approaches to classification of mental disorders**

Classification systems – Mental disorders and conditions can be classified using a *categorical approach* or a *dimensional approach*.

The categorical approach organises and describes mental conditions and disorders in terms of different categories and subcategories, each with symptoms and characteristics that are typical of specific mental conditions and disorders.

The two main diagnostic systems that use the categorical approach of classifying mental disorders are the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** and the **International Classification of Diseases (ICD)**.



The **Diagnostic and Statistical Manual of Mental Disorders** is currently in its 4th edition (DSM-IV) and the 5th edition (DSM-V) is due in 2013. It classifies mental disorders based on recognisable symptoms that are described clearly and precisely for each disorder. The DSM-IV currently describes 365 mental disorders. They are grouped into 16 major categories (eg. sleep disorders, personality disorders, substance-related disorders, etc.). Diagnosis with the DSM-IV involves identification of the disorder that most closely matches the symptoms displayed by the person being diagnosed. The DSM uses *five axes* to identify a person's presenting issues. The DSM system of classifying mental disorders was developed in the USA.

The **International Classification of Diseases** is currently in its 10th edition (ICD-10) and is produced by the World Health Organisation (WHO). It is similar to the DSM in that it is mainly descriptive and makes a diagnosis based on symptoms reported by the patient. And like the DSM, it does not consider either causes or treatments. The ICD is used internationally for both mental and physical illnesses but covers a greater range of physical illnesses than the DSM. The DSM is more commonly used to diagnose mental disorders. However the ICD distinguishes between mental and behavioural disorders, whereas the DSM makes no such distinction. The ICD is more widely used in Europe than the DSM. It was first published in 1893 (and known as the *International Causes of Death*) but did not include mental disorders until 1952 – the same year the first edition of the DSM was published. The ICD is a less detailed categorical system than the DSM.

Strengths and limitations of categorical approaches - Categorical approaches are based on continuing scientific research and regularly revised on the basis of the research findings. They are very comprehensive in terms of the number of disorders they include and the amount of detail presented on each disorder. Another strength of categorical systems is the assistance they provide mental health professionals in diagnosing the mental conditions of their clients so they can subsequently plan treatment

One of the major limitations with categorical approaches to classification of mental disorders was their low inter-rater reliability. Mental health professionals who interviewed the same clients frequently reached different conclusions about the most appropriate diagnosis, and key terms such as 'schizophrenia' were used in different ways in different countries. However, the situation has changed markedly, and both the DSM-IV-TR and ICD-10 have greater inter-rater reliability than their earlier versions. Another limitation of categorical approaches is the loss of valuable clinical information. When human behaviour is classified into categories, the uniqueness of the person is overlooked.

The dimensional approach classifies a person's symptoms or other characteristics of interest in terms of quantity. The focus is on ranking a person's symptoms or other characteristics of interest on quantitative dimensions; for example, a 1-to-10 scale of self-esteem, on which '1' represents little self-esteem and '10' represents a strong self-esteem. Conditions such as autism are measured on a spectrum which is similar to a dimension in that both are types of continuum or sliding scale. At one end of the autism spectrum there are high functioning people and at the other end there are people who are largely incapacitated by the severity of the condition.

- **use of a biopsychosocial framework (the interaction and integration of biological, psychological and social factors) as an approach to considering physical and mental health**

The **biopsychosocial model** for considering mental health is relatively new – developed in 1977 by George Engel. Engel believed in this 'holistic' model that took account of a range of factors and the ways in which they interacted. Previously, mental health had been considered mainly through the biomedical approach which treated the individual purely at a physiological and biological level – ignoring psychological and socio-cultural factors altogether.

Biological factors - This aspect of the biopsychosocial model considers a person's functioning in terms of bodily structures such as the brain and nervous system, biochemical processes and genetic predisposition. It explains behaviour in terms of physiology.

Psychological factors - such as the following are taken into account: personality; perception, cognition, attention and motivation.

Social factors – include such factors as our skills in interacting with others, the quality of our interpersonal relationships, access to support from others, as well as socio-cultural factors such as our cultural values and traditions, family upbringing, schooling, exposure to trauma and stressors, employment history, income and access to medical care.

The biopsychosocial framework reflects a *holistic* view of health. The framework focuses not just on the individual's physical or mental condition, but also their wider social context or circumstances. For example, according to the biopsychosocial framework, a personality disorder might best be explained by the combined influence of an individual's inheritance of certain genes and impaired functioning of a part of the brain that controls impulsive behaviour (*biological* factors), poor self-image and an intense fear of abandonment (*psychological* factors), and their strict upbringing and lack of skills required to develop and maintain social relationships (*social* factors).

- **application of a biopsychosocial framework to understanding the relationship between stress and physical and mental wellbeing:**

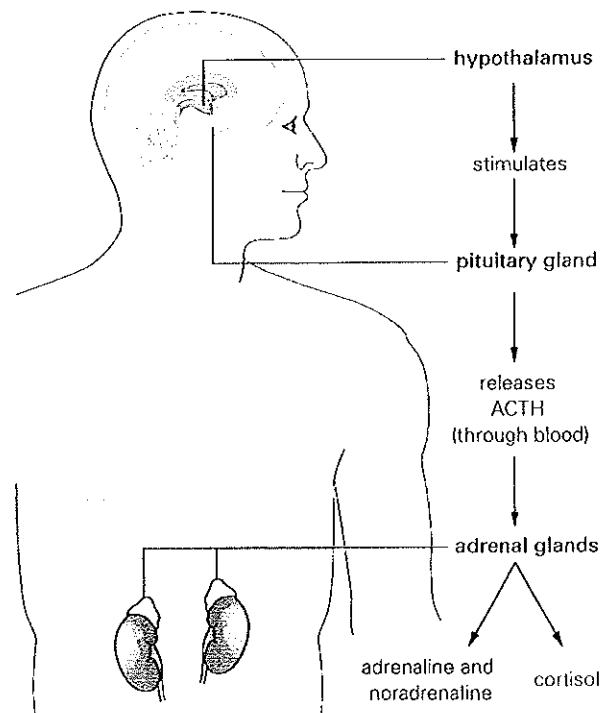
- **physiological and psychological characteristics of responses to stress including fight-flight response, eustress and distress; strengths and limitations of Selye's General Adaptation Syndrome**

The **fight-flight response** refers to an involuntary response by the sympathetic nervous system and the endocrine (glandular) system that produces a state of physiological readiness to deal with a sudden or immediate threat by confronting it ('fight') or running from it ('flight'). The fight-flight response can be triggered not only by physical threats such as being attacked, but also by psychological threats such as the mental stress resulting from an argument or having too much school work. It is considered to be an adaptive response because it aids our survival. Once a threat is perceived, the Hypothalamus is activated to stimulate the Pituitary gland. The pituitary gland releases a hormone that stimulates the Adrenal glands. This chain of events is known as the HPA (Hypothalamus-Pituitary-Adrenal) axis. The adrenal glands secrete stress hormones called adrenaline and noradrenaline which boost the activity of the sympathetic nervous system, increasing heart rate, blood pressure and respiration rate.

This results in more oxygen being made available to the muscles to meet the needs of the fight-flight response.

The adrenal glands also secrete cortisol – a hormone that increases metabolism and the concentration of glucose in the blood for more energy.

Once the threat has been dealt with, the heightened level of bodily arousal returns to normal slowly over a period of about 20-60 minutes.



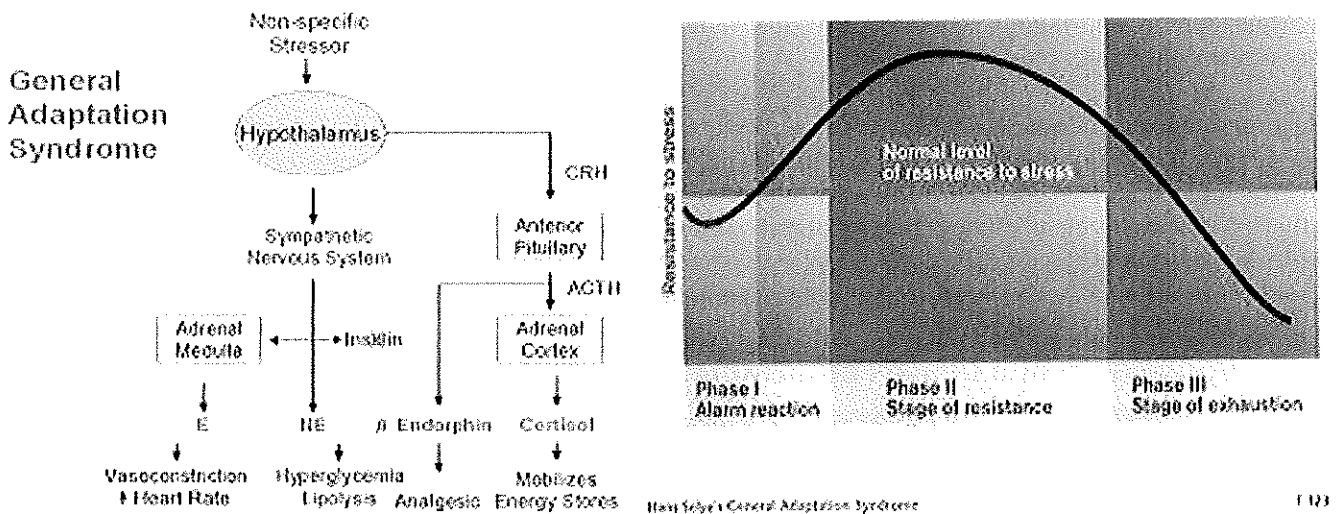
Eustress and Distress. Psychological responses to a stressor may be positive or negative.

Positive psychological responses include feeling mentally active, alert, enthusiastic or excited. Such positive responses are referred to as **eustress**.

Negative psychological responses include anger, anxiety, irritability, nervousness or tension.

Such negative responses are referred to as **distress**.

Strengths of Selye's General Adaptation Syndrome (GAS):



1. Further developed Walter Cannon's findings about the fight-flight response to develop an understanding of the link between stress and disease.
2. Selye was one of the first to suggest that stress could weaken the immune system, increase the likelihood of disease – kidney, heart, and gastro-intestinal diseases and even cancer.
3. Identified some of the physiological mechanisms associated with the stress response.
4. Many of Selye's 1930's findings of the role of the endocrine (glandular) system in the GAS have been confirmed by contemporary researchers.
5. Also, his findings that the body has limited resources to cope with stress had not been previously understood

Limitations of Selye's GAS:

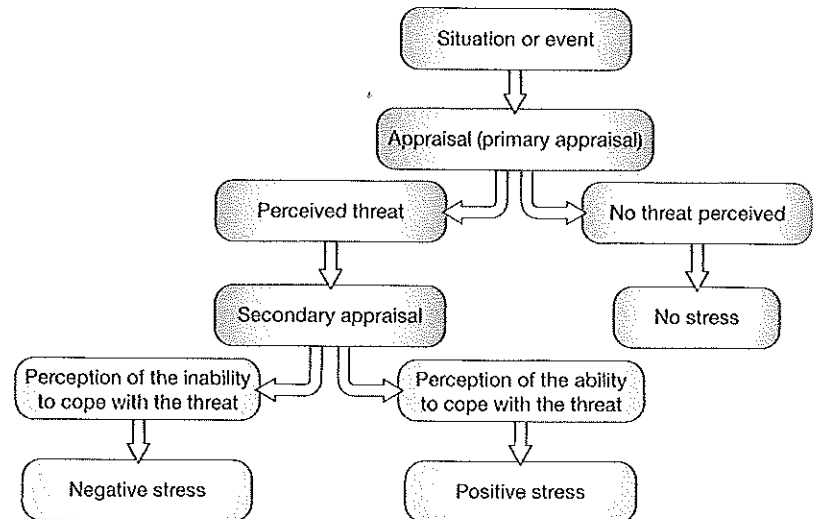
1. The GAS does not take into account individual differences in physiological responses to a stressor – it assumes that everyone has the same general, predictable and automatic responses to any sort of stressor.
2. It tends to focus exclusively on physiological responses and does not take into account our psychological responses to stressors – especially the role of the brain in interpreting a situation as being stressful or not.
3. Selye's GAS has been challenged also on the grounds that all his research was with animals and may be of limited applicability to humans.

– psychological determinants of the stress response; strengths and limitations of Richard Lazarus and Susan Folkman's Transactional Model of Stress and Coping

Lazarus & Folkman's transactional model of stress and coping proposes that stress involves an "encounter" or "transaction" between the individual and their external environment. It also proposes that the stress response depends on the individual's "appraisal" (interpretation) of the stressor and their ability to cope with it. They contend that stress is not the result of an individual's interpretation alone nor the result of the environment alone, but rather an interaction between the two. The environment can influence the individual or vice versa.

An individual's appraisal of the situation and their resources for dealing with it, determine whether they experience a stress response and the nature of their stress response. When there is an imbalance between a person's appraisal of the demands of the situation and their estimation of their ability to meet those demands, then a stress response will be experienced.

Lazarus & Folkman's model of stress and coping makes a distinction between two different kinds of appraisal of a situation and refers to these as the *primary appraisal* and the *secondary appraisal*.



The **primary appraisal** involves an **evaluation of the significance of the situation**. For example: “Does this really affect me?” or “Does it really matter?”

The outcome of the primary appraisal involves a decision about whether the situation is:

- (a) irrelevant; (b) benign-positive; or (c) stressful

Only if we decide that it's stressful do we engage in additional appraisals. These involve:

1. Harm/loss – How much damage has occurred already? Eg. Have I failed this subject?
2. Threat – an assessment of the harm/loss that hasn't occurred yet, but could do so in the future. Eg. I mightn't be able to pay my mobile phone bill; and
3. Challenge – an assessment of the potential for personal growth or gain from the situation. Eg. I'll learn from the feedback on this job interview and improve my skills for the next one.

In a **secondary appraisal** we **evaluate our coping options and available resources**. These may be internal (strength and determination) or external (financial resources, support from friends).

Lazarus & Folkman also describe a series of coping mechanisms. Coping involves constantly changing cognitive and behavioural efforts to manage specific internal or external stressors. Coping therefore attempts to manage the demands of the stressor in an effective manner.

There are various types of coping strategies and they are classified as *problem-focused* or *emotion-focused* coping.

Problem-focused coping involves managing or changing the source of the problem. These tend to be used when we believe we have some control over the situation. Eg. I can lower my expenses to save for a badly needed new car.

Emotion-focused coping involves strategies directed towards the emotional part of a stress response. These tend to be used when we feel we have little or no control over the situation. Eg. Denial – “I'm not stressed”; Distancing – “I'm not letting it get too me”; Minimising – “It's not that bad”; Acceptance “Nothing can change this situation.”

Strengths of Lazarus & Folkman's Transactional Model of Stress & Coping

- 1) Instead of focusing on the physiological responses of the autonomic nervous system like Selye's GAS model, L & F's model emphasises the psychological factors behind the stress response – because we have some control over these (unlike the involuntary physiological responses), their model emphasises individual differences in the stress response.
- 2) Lazarus & Folkman's model focuses on the individual's interaction with their environment. This gives the individual an active role - making personal appraisals of the situation - compared with the passive role of the individual in Selye's model which lacks any emphasis on the individual's ability to interpret situations or think things through.
- 3) The previous point also emphasises that different individuals respond in different ways to the same stressors.
- 4) The reappraisal process of this model allows for the effects of stressors to change over time.
- 5) The Lazarus & Folkman model also proposes different methods for managing psychological responses to stressors and has therefore helped our understanding of the importance of stress management strategies and programs.

Weaknesses of Lazarus & Folkman's Transactional Model of Stress & Coping

- 1) It is difficult to test this model through experimental research because of the subjective nature of psychological responses to stress – i.e. the complexity and variability of individual responses to stressful experiences; and
- 2) Primary and secondary appraisals often happen simultaneously and interact with each other. They are therefore difficult to study as isolated variables.

– **social, cultural and environmental factors that exacerbate and alleviate the stress response**

Social factors that can influence the stress response include our relationships and social interactions with others. Such factors range from loneliness and feelings of isolation from other people or the wider community to change in one's existing social relationships; for example, adjusting to, breaking up or reconciling a relationship. These factors include lack of social skills in forming and maintaining relationships with others, lack of social support, being in a bad relationship, making a new friend or gaining a new family member, experiences during social and recreational activities, being a victim of discrimination or bullying, and virtually anything else that involves some kind of interaction (or lack of) with one or more people.

Cultural factors - For immigrants, refugees and asylum seekers coming to Australia and other countries, emigration can be a means of escaping famine, poverty, torture, persecution, civil unrest, political turmoil or war. Therefore, it can serve as a means of alleviating the stress response. However, the demands of adjusting to a new culture can produce or exacerbate the stress response. Establishing a new life in one's adopted country can be a very difficult and challenging adjustment, especially when there are significant cultural differences.

Environmental factors that can influence the stress response include crowding, loud noise, air pollution, extremes of temperature and catastrophes such as technological and natural disasters. Crowding is one of the first environmental factors influencing the stress response to be scientifically studied through experimental research.

- **allostasis (stability through change brought about by the brain's regulation of the body's response to stress) as a model that integrates biological, psychological and social factors that explain an individual's response to stress**

Allostasis is the process whereby stability through change is maintained in the face of stressors. It is an adaptive process – the body adapts and changes to cope with the stressors and maintain as normal a state as possible. The body has a number of mechanisms with which to implement this adaptive response to stress. One of these is the **HPA axis: Hypothalamus; Pituitary gland; Adrenal gland**. When a threat is perceived the hypothalamus is activated. The hypothalamus stimulates the nearby pituitary gland. The pituitary gland secretes a hormone that stimulates the adrenal glands.

Allostasis therefore enables an individual to adapt to the demands of the stressor by initiating a state of physiological arousal which is “turned off” when it is no longer needed. **Allostatic load** refers to the prolonged exposure to an increased production of stress hormones. This involves excessive wear and tear on both mind (eg. anxiety and depression) & body (eg. cardiovascular disease, immunosuppression, diabetes).

- **strategies for coping with stress including biofeedback, meditation/relaxation, physical exercise, social support**

Biofeedback- is a technique that enables an individual to receive information (*feedback*) about the state of a bodily process (*bio*), and with appropriate training, to control a related physiological response using thought processes. During *biofeedback training*, electrical or mechanical sensors, like electrodes used on the EEG or a blood pressure cuff, are attached to the person. These sensors respond to a particular physiological response, such as tension in a particular muscle, blood pressure or skin temperature. The signals that are detected are then analysed and displayed to provide the person with information about the state of the relevant bodily process.

Meditation is an intentional attempt to bring about a deep relaxed state in order to reduce one or more effects of stress-related symptoms. The term *meditation* is sometimes used interchangeably with *relaxation* because meditation involves relaxation, and a relaxed state can be achieved by using a meditative technique. However, relaxation does not necessarily require the use of a meditative technique.

Relaxation also brings about a state of reduced psychological and/or physiological tension. One way of relaxing is to meditate, but there are numerous other relaxation techniques.

Physical exercise is physical activity that is usually planned and performed to improve or maintain one's physical condition. For example, going for a walk or a run to improve your fitness and doing bicep curls to develop upper-arm strength all involve physical activity considered to be physical exercise because they have the goal of improving physical condition.

Social support is help or assistance from other people when needed. The people who provide social support can vary and include anyone with whom we may have a relatively stable or ongoing interpersonal relationship, although this does not necessarily mean a close interpersonal relationship or an intimate relationship. People who may provide social support can include family members, friends, neighbours, work colleagues, peers at school, teachers we trust, fellow members of a church or self-help groups.

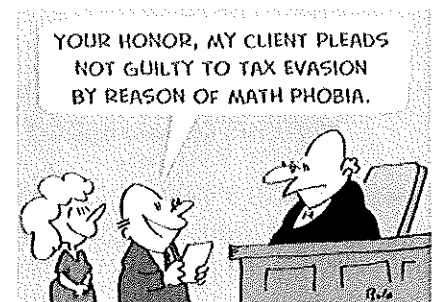
- **application of a biopsychosocial framework to understanding and managing simple phobia as an example of an anxiety disorder:**

- **biological contributing factors: role of the stress response; role of the neurotransmitter gamma amino butyric acid (GABA) in the management of phobic anxiety**

Anxiety is a state of physiological arousal associated with feelings of apprehension, worry or uneasiness that something is wrong or that something unpleasant is about to happen.

Mild to moderate anxiety can make us more alert and improve our ability to cope. If anxiety is severe or exaggerated and does not subside, it can be counterproductive and disabling. For example, it reduces our ability to concentrate, learn, think clearly, plan, etc.

A **phobia** is an excessive or unreasonable fear directed to a particular object, situation or event that causes significant distress or interferes with everyday functioning. The term 'phobia' is Greek for 'fear' or 'in dread of'. People with a phobia often become fearful even when they think about the object, situation or event they dread. However, they can usually keep the anxiety associated with their fear at a manageable level as long as they avoid the object or thoughts about it.



A **specific phobia** is a disorder characterised by significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behaviour. The specific object or situation producing the fear associated with a phobia is commonly referred to as the *phobic stimulus*.

Subcategories of phobic disorders

- ❖ **Social phobia** - involve a fear of other people or social situations (includes the fear of being scrutinised by others while eating, speaking in public or attending a party).
- ❖ **Simple phobia** – fear of a single specific object or event that triggers a panic response (for example : spiders, snakes, heights, blood etc).
- ❖ **Agoraphobia** – fear of leaving a familiar place such as home. Can be made worse by the accompanying fear of getting a panic attack.

Four main types of simple phobia:

1. animal phobias – fear of snakes, spiders, rats or dogs
2. natural environmental phobias – fear of heights, storms, water or darkness
3. situation phobias – fear of enclosed spaces, elevators, flying, dentists or driving
4. blood-injection- injury phobias – fear of medical procedures or sight of blood

Role of the neurotransmitter gamma-amino-butyric acid (GABA) in the management of phobic anxiety
GABA is the primary *inhibitory neurotransmitter* in the central nervous system and works throughout the brain to make postsynaptic ('receiving') neurons *less likely to fire* (that is, it 'inhibits' firing). Without the inhibitory effect of GABA, activation of postsynaptic neurons might get out of control and spread throughout the brain, causing seizures like those of epilepsy. The inhibitory action of GABA counterbalances the excitatory activity of another neurotransmitter called glutamate and vice versa. Consequently, GABA and glutamate have important roles in regulating central nervous system arousal. GABA is also believed to play a role in anxiety.

Low levels of GABA lead to higher levels of anxiety as there is not enough GABA to adequately regulate anxiety or arousal. Anti-anxiety drugs that mimic GABA's inhibitory effects have been successfully used with other treatments to manage phobic anxiety.

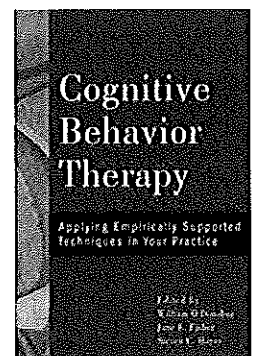
6 – **psychological contributing factors: psychodynamic, behavioural and cognitive models; the use of psychotherapies in treatment including cognitive behavioural therapy (CBT), systematic desensitisation and flooding**

The **psychodynamic model**, or psychodynamic theory, is based on an assumption that all mental disorders are caused by unresolved psychological conflicts that occur in the unconscious part of the mind, beneath the level of ordinary conscious awareness. These conflicts have their origins in early childhood experiences during which our instinctive ‘urges’ and what is ‘acceptable’ behaviour often clash. According to Freud, the *unconscious* part of our mind is a storage place for all the information about ourselves that is not acceptable to the conscious mind. Although you are not directly aware of your unconscious thoughts and feelings, Freud believed they still have a considerable influence over your conscious thoughts and behaviour.

According to the **behavioural model**, phobias are learned through experience and may be acquired, maintained or modified by environmental consequences such as rewards and punishment. Traditional behavioural models are based on the learning theories of Pavlov, Watson and Skinner. It should therefore not be surprising that behavioural models assume that phobias—like most other ‘abnormal’, or dysfunctional, ways of thinking, feeling and behaving—are learned through classical and operant conditioning processes in much the same way as ‘normal’ ways of thinking, feeling and behaving are learned. Generally, explanations of phobias by behavioural models propose that classical conditioning processes play a role in the *acquisition* of a specific phobia and operant conditioning processes play a role in the maintenance of specific phobia.

A **cognitive model** focuses on how the individual processes information about the phobic stimulus and related events. For example, explanations of phobias from a cognitive perspective tend to examine how people with phobias tend to think about a phobic stimulus and its context, and their perceptions, memories, beliefs, attitudes, biases, appraisals, expectations and other cognitive processes that may be relevant. While there is recognition of the role of conditioning and other types of learning in the development and persistence of a phobia, cognitive models emphasise how and why people with a phobia have an unreasonable and excessive fear of a phobic stimulus.

Cognitive behavioural therapy (CBT) uses a combination of verbal and behaviour modification techniques to help people change irrational patterns of thinking that create a phobia. CBT focuses on helping the person change negative thoughts (flies can kill me) and replaces them with more positive, realistic ones (flies are unpleasant but they won’t hurt me if I’m careful). The negative thoughts that spring to mind when confronted with the feared object or event are known as automatic thoughts. The cognitive behavioural therapist seeks to modify these thoughts so that the person no longer experiences the phobic response. In turn, this reduces the person’s behavioural tendencies to avoid the feared stimulus.



Systematic desensitisation is based on the assumption that most anxiety responses are initially acquired through classical conditioning, therefore eliminating a simple phobia can be achieved through counter-conditioning or by weakening the association between the conditioned stimulus (for example rat, needle, flying) and the conditioned response of fear or anxiety. This is done in three steps:

1. The therapist helps the client build an anxiety/fear hierarchy. The client makes a list of anxiety-causing stimuli that are linked to their simple phobia, from least anxiety/fear-inducing to most anxiety/fear-inducing.
2. The therapist trains the client in deep muscle relaxation.
3. The client tries to work through the hierarchy, learning to remain relaxed while imagining each stimulus on their hierarchy. This is repeated until the person can imagine each situation or object with little or no anxiety/fear.

The aim of systematic desensitisation is to recondition people so that the feared object, animal or situation (the conditioned stimulus) elicits relaxation rather than fear or anxiety.

Flooding, sometimes known as exposure therapy, is a behavioural psychotherapy based on the premise that phobias are learnt through classical conditioning but, unlike systematic desensitisation where the person is gradually exposed to the object of the phobia, patients are actually exposed at once and for prolonged periods to the feared stimulus. Patients are subjected to high levels of anxiety which they seek to replace with feelings of relaxation. Although this method can achieve quicker results and has been successful in treating simple phobia, it is not suitable for all people as it can increase rather than decrease their phobia and has a greater incidence of spontaneous recovery of the phobia than other methods.

– socio-cultural contributing factors: specific environmental triggers such as being bitten by a dog; parental modelling and transmission of threat information

Social and cultural factors can contribute to the type and incidence of simple phobia. Research has found that a child whose parent suffers from a particular phobia (eg dogs), is more likely to develop a similar phobia as a result of simply observing their parent's fear response and making the cognitive (mental) connection that 'dogs are dangerous'.

Some phobias are specific to a culture; that is, they occur almost exclusively in a particular culture. In many instances, **environmental triggers** can lead to the development of a phobia. There are three possible environmental paths:

- 1) direct exposure to a distressing or traumatic event, such as being bitten by a dog
- 2) witnessing other people experiencing a traumatic event, such as seeing another person being mauled by a dog (observational learning)
- 3) reading or hearing about dangerous situations or events, for example, developing a fear of dogs after hearing stories about children, adults or family pets being attacked by vicious dogs.

Parental modelling and the transmission of threat information-

Bandura's social learning theory combined cognitive and behavioural theories to argue that a great deal of our behaviour is learnt through imitating or modelling other people's behaviours. It was suggested that simple phobias can be learnt vicariously, by observing other people's phobic reactions. Suppose a child is raised in a household where a parent is terrified of dogs. Each time the parent sees a dog, they show fear by screaming and running from the dog. This in turn increases the child's anxiety and leads the child to believe that dogs are dangerous. Children who are exposed to parents with phobic responses are more likely to develop comparable fears to similar stimuli. Thus, **parental modelling** can lead to the **transmission of threat information** which becomes incorporated into the child's long term memory.

– the interaction between biological, psychological and socio-cultural factors which contribute to an understanding of the disorder and its management

Therapists take a holistic approach to treating simple phobia and consider the following factors:

- genetic vulnerability and inherited personality predisposition
- physiological processes
- psychological determinants
- socio-cultural factors
- family history of anxiety and simple phobia
- environmental influences
- symptoms and whether the person can function effectively at work, home and socially

The **biopsychosocial approach to simple phobia** incorporates three major elements: biological, psychological and socio-cultural.

The biological factors of this model refer to the body's physiological makeup and how the brain processes and responds to fear. It incorporates the influence of genetics, in terms of inherited vulnerability to anxiety disorder and the potential effect of being born with a highly sensitive and easily startled personality predisposition.

The psychological factors include thoughts, beliefs, personal experiences and perceptions. The environment can influence whether or not we interpret events around us as a source of danger. These interpretations can play an important role in the development of an anxiety disorder such as simple phobia. Indeed, cognitive distortions or thinking errors are characteristic of phobia, as individuals overestimate the perceived level of danger and experience a stress response and/or use avoidance strategies to alleviate the distress.

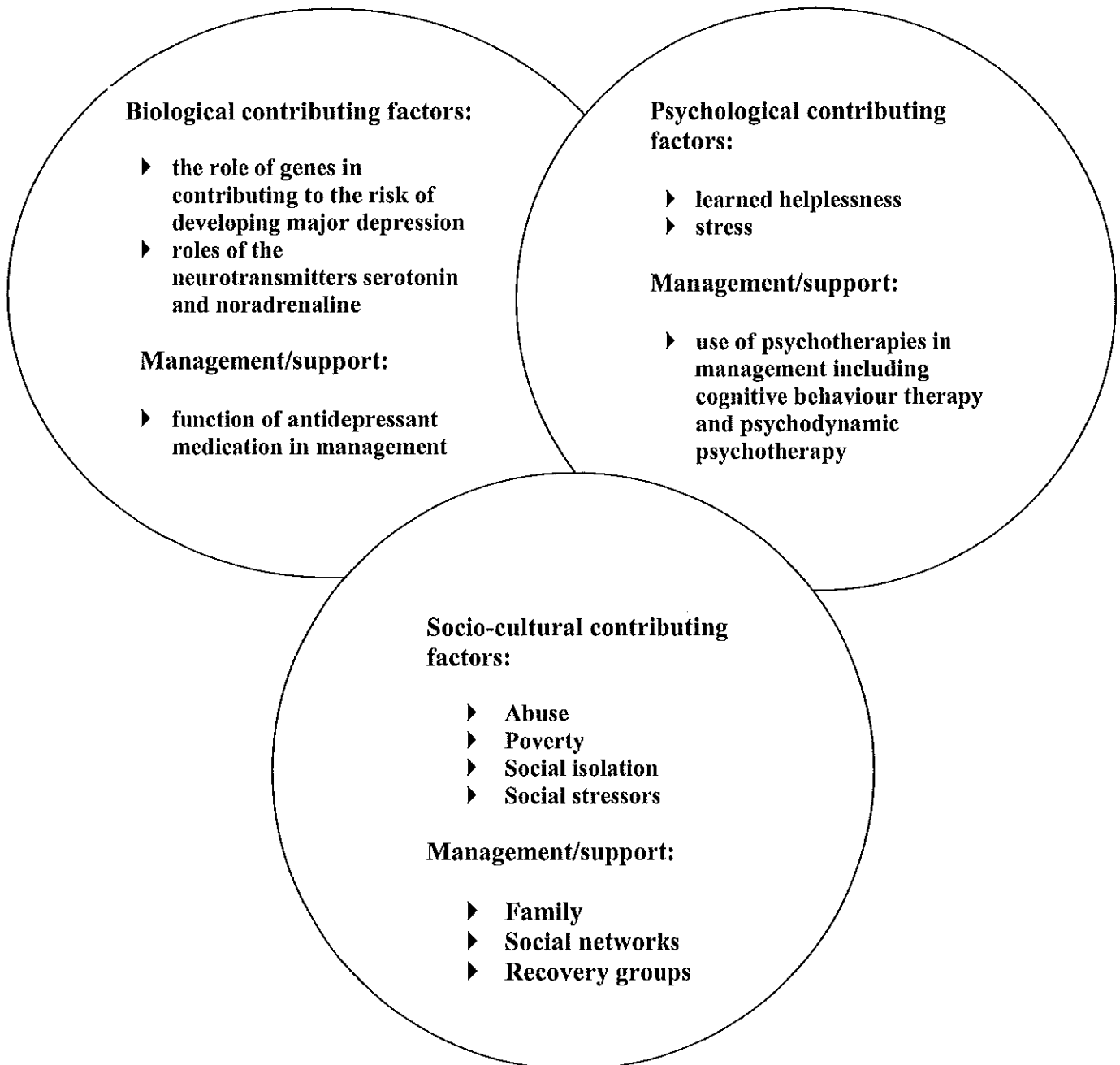
The socio-cultural factors may activate, shape and strengthen any biological and psychological vulnerabilities and lead to the development of simple phobia. Phobia can be learnt initially through classical conditioning and avoidance behaviours may be reinforced through operant conditioning. Learning to fear objects and/or situations can also occur by observing family and other significant people in our social environment (i.e. observational learning).

Biological, psychological and socio-cultural factors should all be considered when treating social phobia to ensure the most effective therapeutic outcome

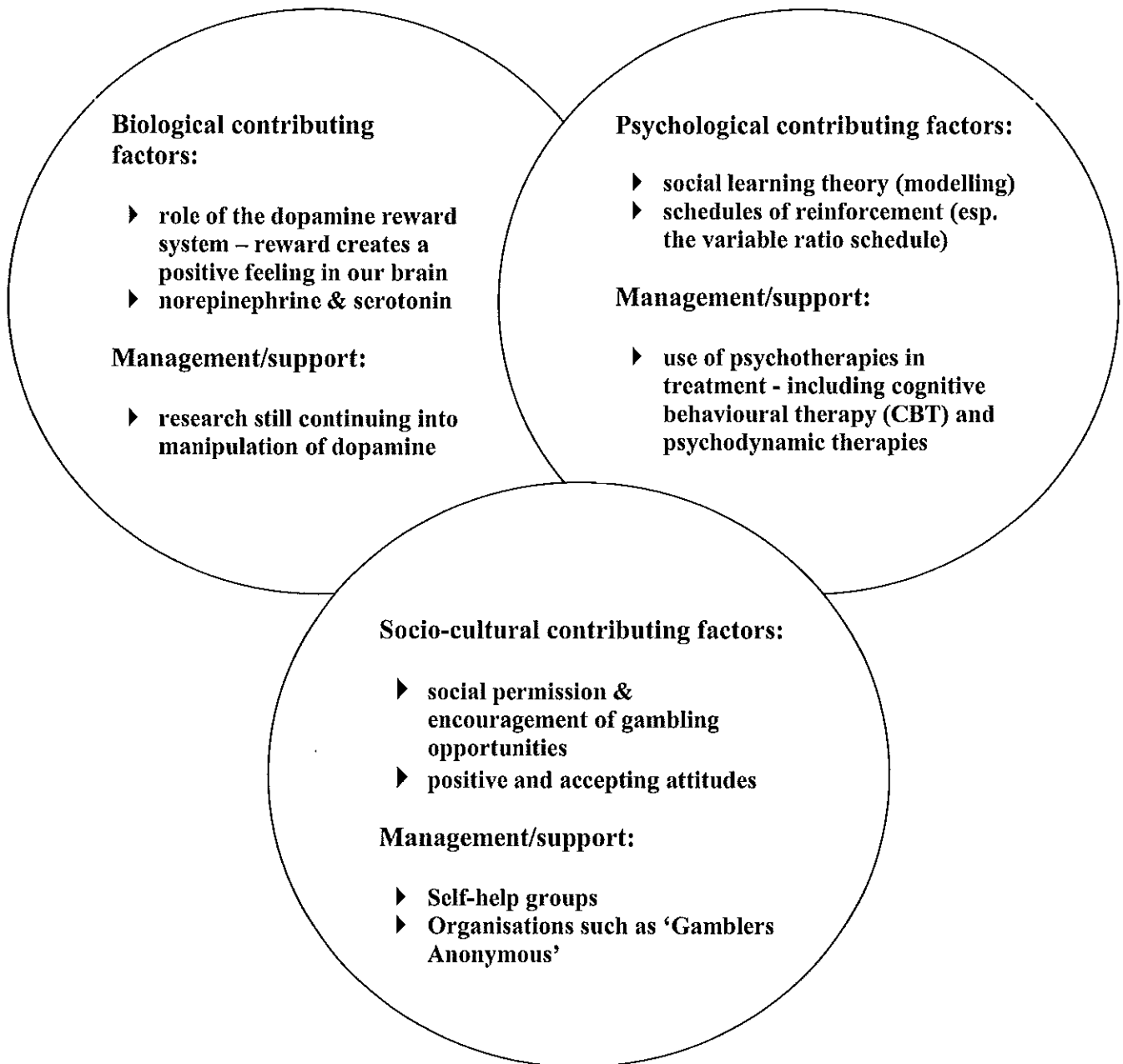
OPTIONS

- application of a biopsychosocial framework to understanding ONE of the following types of mental disorder and its management:

1. Mood disorder: major depression



2. Addictive disorder: gambling



3. Psychotic disorder: schizophrenia

